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ORIGINAL ARTICLES

STATE HOSPITAL FOR MENTAL DISEASES.*

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From inquiries received at the office of this Hospital from members of the medical profession it is evident that in the minds of many of the physicians of this State there is a lack of accurate information or a vague conception of the relationships and functions of the institutions of the State located at Howard, Rhode Island. This is not surprising, for by common usage all these institutions are grouped under the term "State Institutions," a designation which has crept into official use without there being a specific warrant for the use of the term in statutory language. Again these institutions have all been under the control of a central governing body from the time of their establishment and for several years these institutions, with the exception of the State Prison, were administered by one superintendent. In order to make the present situation clear to the medical profession of Rhode Island, we will enumerate the institutions of the State located at Howard and present features relating to them individually in the attempt to clearly differentiate them and their functions. The property of the State in land at Howard comprises nearly 900 acres. The following institutions are located within this area:

I. State Prison and Providence County Jail, Warden, Charles E. Linscott.

II. Oaklawn School for Girls, Superintendent, Catherine J. Tobin.

III. Sockanosset School for Boys. Superintendent, Donald North.

IV. State Workhouse and House of Correction, Superintendent, Ira E. Higgins.

V. State Infirmary, Superintendent, Henry A. Jones, M. D.

VI. State Hospital for Mental Diseases, Superintendent, Arthur H. Harrington, M. D.

While all of these institutions are near neighbors to one another, yet the only feature which is common to them all, as far as their individual, internal and local management is concerned, is that the head of all these separate institutions report to one body, namely, the Penal and Charitable Commission. The purpose for which these several institutions are carried on have a wide divergence and consequently the methods of carrying out their functions must vary.

We can divide all of these institutions into two groups, namely, the penal and reformatory group to which belong the State Prison and Providence County Jail, Sockanosset School for Boys, the Oaklawn School for Girls, the State Workhouse and House of Correction. With this group we do not for the purpose of this paper need to make any further statement than to emphasize the fact that in their local and internal management they are entirely distinct from one another and their heads have no official relation with one another. The second group comprises the two charitable institutions, namely, the State Infirmary and the State Hospital for Mental Diseases. As far as local and internal management is concerned these two institutions have no relationship one to the other. The superintendents of these two institutions have no official connection, whatever, with one another.

The State Infirmary cares for the aged, feeble, and the physically incapacitated, who reach the Infirmary because they have no one to give them proper care and because they are indigent. The Infirmary has an active Lying-in Department. The Infirmary receives many cases of physical illness both acute and chronic, such cases being received there from cities and towns of the State and from various hospitals. All cases received at the Infirmary are admitted upon an order issued by the Penal and Charitable Commission.

Coming now to the State Hospital for Mental Diseases we have an institution which is devoted to the treatment of mental diseases and for this

*Read before the Rhode Island Medical Society, September 1, 1921.

purpose only. It is an institution which in its local and internal management is distinct and independent like all of the institutions above mentioned. This is the point which I wish once more to emphasize and in regard to which so much confusion exists. This institution now known as the State Hospital for Mental Diseases received its first patients on the 7th of November, 1870. It was then called the State Asylum for the Chronic Insane. Up to 1885, the purpose was that no cases should be received here unless they had had treatment for mental disease in some reputable hospital devoted to the care of such cases. In 1885, in connection with the State Care Act the direct commitment of recent and acute cases of mental disease was authorized. Until 1897 this Hospital was conducted under a lay superintendency. In that year the first medical superintendent was appointed. The developments which have taken place since that day have been in the line of establishing a hospital for the State of Rhode Island for such mentally sick persons as must receive treatment in a State Hospital. Since the opening of the Hospital in 1870 there had been received up to January 1, 1921, 11,805 cases. The average number of yearly admissions during the past five years has been 445. The daily average number of cases during the Hospital year of 1920 was 1,376. The total number of cases treated during that year was 1,919.

In our annual report of this Hospital of 1909 a program was presented setting forth the requirements for the development of this Hospital necessitated on the grounds of sanitary housing, provision for the increasing number of patients, adequate buildings and equipment for the domestic side of the institution, and organization for the medical handling of the work. We are enabled to-day to record the following accomplishments: The original structures of wood with which this Hospital opened have been torn down. A Reception Hospital for acute cases and recent admissions was opened in 1912. A laundry building equal to any increase of patients up to twice the present number was finished in 1915. In 1916 we opened a building for men, a three-story, fireproof structure with a capacity for 316 patients. In August, 1917, we occupied a group of buildings known as the L-Group. This group accommodates 410 women patients. A structure dating from the early days of the Hospital but having external walls of substantial masonry was remodelled, renovated and occupied as a hospital ward for women in the year 1917. A Domestic Service Building of ample proportions and equipped with cold storage plant and modern conveniences was occupied in 1916. Such, therefore, has been in the main the constructive work of recent accomplishment, the funds for which have been furnished from bond issues to the amount of $900,000 and from some special appropriations which have been authorized from time to time by the General Assembly. The fact is that the problem in which we have been engaged has been practically the building of a State Hospital, a large portion of it from the foundations up. The idea seems everywhere prevalent that with all these building operations that we must have ample room for patients, not only at the present time but for an indefinite time to come. The true facts are, however, quite contrary to this general impression as can readily be seen in the following statement: In 1910 the daily average number of patients was 1,100 in round numbers. To-day in round numbers we have over 1,400 patients. The normal capacity of this Hospital is considered to be 1,385 patients. The capacity of the old buildings which we have abandoned and which have been razed to the ground has had to be made up in our new buildings and at the same time we have had to accommodate the natural increase in the number of patients over a period of 10 years, so that to-day we find ourselves with actually 25 patients over the normal capacity of the Hospital. This last consideration has a distinct bearing on the future progress of this Hospital. This Hospital should to-day have an appropriation of at least $500,000 to provide for the very present growth in this Hospital, which I believe is sure to take place. Aside from the physical upbuilding of the hospital plant substantial gains have been made in the medical care of the patients. The effort is being made to give the patients the advantage of every kind of physical care necessary or desirable. The Hospital has on its Visiting Staff physicians who are engaged in nearly every spec-

ialty. We have made the beginning of the establishment of a Pathological Laboratory. It is the aim to develop this labaratory in such manner as to make it of practical service to the living patient with such departments and personnel as such a laboratory requires. This Hospital should be able to serve the medical profession and the community in a manner which keeps pace with all the scientific advances of our times, but without proper financial support the functions of this Hospital are bound to be curtailed.

One great need at the present time is adequate financial means to carry out all the functions which a hospital of this kind is expected to perform in order to serve the State as it should be served.

PSYCHOSES FOLLOWING HEAD INJURY.

ARTHUR H. HARRINGTON, M. D.

There is an opinion quite prevalent among the laity that head injuries are a prominent cause of mental disease. This attitude is frequently encountered in taking the previous histories of patients. It is not uncommon for friends to recall the occurrence of some injury to the head, which from its description and also from its remoteness to the onset of the mental symptoms of the patient, must be regarded as negligible as a cause of the patient's mental condition. It is quite probable, moreover, that the fact of this remote injury would not have been revived at all except for the suggested association brought about by the occurrence of the mental symptoms.

Furthermore, it is very probable that the older writers too readily set down head injuries as causes of mental disease and in some instances it is quite apparent in the light of the present knowledge that some authors have mistaken a result for a cause.

The statistical records of hospitals for mental disease and of psychiatrists have differed appreciably in the frequency with which mental disease is attributed to head injury.

Clevenger, while pathologist at the Chicago County Asylum, in 357 cases in which the causes of mental disease were ascertained, determined that 27 of these were caused by head injuries. Schlager found 49 cases of mental disease out of a total of 500 due to the same cause. Esquirol, out of 737 cases of mental disease, attributed 22 as due to blows or falls on the head, while Clouston encountered but 12 cases of mental disease attributed to head injury in a period of nine years at the Royal Edinburgh Asylum.

From the totals of the observation of various authors the proportion of mental disease ascribed to head injury approximates 6% of all cases. Of the cases seen in Hospitals for Mental Diseases the writer is inclined to regard this percentage as too great.

Between January, 1908, and July 1, 1921, 5,429 cases were admitted to this Hospital. Only 17 of these cases were diagnosed as "Psychoses Due to Head Injury."

The statistics relating to head injury as a cause for mental disease must be revised and some of the observations of authors eminent in their day must not be allowed weight at the present time. For instance, in the 1878 Lunacy Blue Book for England and Wales, of 1,221 cases of paretic dementia, 46 were set down as caused by cranial injury.

Among the effects upon the central nervous system of traumatism we may have two classes of manifestations; the one being designated as traumatic neuroses and the other as traumatic psychoses.

In this paper we shall not discuss the traumatic neuroses, for they present an entirely different picture from the traumatic psychoses as we classify them. We shall further in this paper limit our subject to those traumatic psychoses which follow head injuries.

The mental disturbances following blows or falls upon the head present psychotic symptoms of a fairly characteristic kind. The amount of damage to the brain may vary from extensive destruction of the tissue to simple concussion. There may or there may not be fracture of the skull.

The common clinical types of traumatic psychoses are divided into three varieties. These three varieties constitute the usually accepted classifications at the present time. They are:

I. Traumatic Delirium: This may take the form of an acute delirium or a more protracted

delirium, resembling the Korsakow mental complex.

II. Traumatic Constitution: Characterized by a gradual post-traumatic change indisposition. That is, the personality may undergo a marked transformation in which the individual may be incapable of continued effort, there may be irritability or explosive emotional reactions. In some cases there is the development of delusional states of a paranoid nature.

III. Post-traumatic Mental Enfeeblement: In which there are varying degrees of mental reduction.

The following cases out of the 17 traumatic psychoses diagnosed in this Hospital since 1908 correspond fairly well to these three types of traumatic psychoses.

As an example of traumatic delirium we will cite Case No. 10,932, a male, 58 years of age, fell from a third story of a building to the ground, received a fractured skull. The plates showed an oblique linear fracture of the right side of the skull extending through the lower portion of the right parietal bone into the squamous portion of the temporal bone. He was taken to a general hospital where he remained six weeks. No operation was performed. On admission to the general hospital he was unconscious for a period. He became incoherent, constantly called to his wife. He appeared to have hallucinations of hearing. On admission to this hospital he was greatly confused and disoriented Three weeks after admission he began to make rapid improvement, his confusion and disorientation and hallucinations vanished. He remained in this hospital about five weeks. On leaving the hospital 11 weeks after the time of the accident, he resumed his occupation, which was that of a janitor. He was seen by the staff of this hospital six months later and appeared well.

As a second instance under Type One, we will cite Case No. 9,064, a woman, 29 years of age. She was thrown from an automobile, receiving injury to the head, but without diagnosis of fracture. She received other bodily injuries. She was first taken to a general hospital, where she remained about two weeks. The patient was unconscious for a few hours but cleared up and her mind appeared normal for about one week. After this lapse of time she became noisy, and finally so maniacal in her manifestations that she was committed to this Hospital. On admission she was clouded, disoriented and given to fabrication. She made a rapid improvement however. She remained in this Hospital less than two months and was regarded as recovered at the time of leaving, which was a little less than ten weeks from the receipt of the injury. This case is also an instance of what may occur in some cases of head injury. That is, a period of apparent normal mentality on regaining consciousness, but with the development later of symptoms of marked mental disturbance which happily in this was of comparatively short duration.

Case No. 10,572, corresponds to Type Two, characterized as Traumatic Constitution. On January 3, 1910, this man, when 52 years of age, fell from a ladder, receiving a fracture of the skull. He was first treated in a general hospital. This man had been married for 20 years at the time of his accident and had two children. His disposition had always been good and he was thoughful and considerate of his family. He remained in the general hospital for about six weeks. He had a period of unconsciousness lasting several days immediately following the accident. On his return to his home he very early showed a complete change in personality. He became cross and abusive, so that he was very difficult to live with. After a time he returned to his work, namely, that of a painter. In this he became less productive as time went on and finally gave it up. He would remain at home and stay in bed all day. He had emotional outbreaks, when he would destroy furniture. He began to have paranoid trends, such as suspicion of his wife's fidelity and ideas of poisoning. He became suicidal. From the years 1916 to 1918, he was cared for in a private institution. On January 28, 1918, he was committed to this Hospital, where he remained to the time of his death, June 30, 1921. Following admission he showed no change for the better. His memory was impaired. There was an entire absence of insight.

As an example of Type Three, Post-Traumatic Mental Enfeeblement, we will cite Case No. 8,621, a male, 61 years of age when admitted to

this Hospital on July 20, 1913. On July 5, 1913, patient was struck by an automobile and received an injury to the head. He was rendered unconscious and taken to a general hospital. No fracture was demonstrated. In a few hours' time he became delirious and so much disturbed that he was committed to this Hospital fifteen days later, where he has remained ever since. He was confused, irritable and restless when admitted here. He had speech defect, tremor of tongue and fingers, exaggerated patellar reflexes, pupils unequal and irregular. He is disoriented, clouded, with impaired memory for recent and remote events, attention blunted, rambling thought and absence of insight. At the present time he is markedly demented, rambling in thought and has no insight. Before the accident he is said to have been a rugged man. His Wassermann on the blood was negative.

In regard to the pathology of psychoses following head injury very little has been written. Kraeplin states that autopsies in fresh cases of brain injury often show no extensive lesions outside the immediate point of injury. However, later, there may be extensive degeneration of nerve tissue in apparently circumscribed injuries. We will have to assume, therefore, that finer disturbances go on far outside the original point of impact. Often nerve cells and the fibers dependent upon them may degenerate quite extensively.

It seems to me in the case of Type One, namely, Traumatic Delirium, in which after a few days, a few weeks or even a considerable longer period, there appears to be a complete recovery that following the injury there may be an edema of brain tissue, and the course and duration of the case will depend upon the readiness with which the edema is absorbed. It would seem not improbable that after an edema exists in a given area for a considerable period that this might set up degeneration of cellular and other brain structures.

WHOM SHOULD WE COMMIT?*

By Geo. B. Coon, A. M., M. D.,
State Hospital for Mental Diseases, Howard, R. I.

It is a singular fact that while the history of medicine covers a period of over 4,000 years, it has been but little over a century that any consideration has been given to the diseases of the most important organ we possess. So fathomless have seemed the capacities of human minds. so multifarious their manifestations, that men steeped in superstition from prehistoric time have found a simple and easy explanation for eccentric manifestations by attributing them to evil spirits—believing the cause to be dependent upon a defective personality or some extraneous evil influence, rather than to any functional or organic disease of the brain itself.

One reads with interest and some little amusement the report of the Superintendent of a Massachusetts Insane Hospital for the year 1820, in which he states, as evidence of his humane and advanced treatment, that upon pleasant days the patients were drawn out upon the lawn in their cages that they might enjoy the fresh air and sunshine.

Although the subject of insanity has now been studied for a hundred years and quite intensively for the past fifty, the study still seems but in its infancy. No definition of the term has ever been formulated that will stand the analysis of the courts and few of the recent books attempt to define it A recent writer has rejected the term in its accustomed sense and instead defines it, not as a disease. but as a term applied to a class of people in the social scale who are unable to adapt themselves to their environment, which for our purpose to-day meets the situation very well and renders more easy the answer to the question "Whom should we commit?"

The layman as a rule seems to recognize but three types of mental disease, the maniac, the fool and cases of "softening of the brain"—the latter term covering all forms of advanced dementia. Many physicians who have not had the advantage of the teaching of the past 25 years will frankly admit that this classification also satisfies them and they are not prepared to enlarge upon it. However, it is upon the general practitioner that the responsibility devolves for the committal of most of the insane, and it is but fitting that he should be given a few hints as to the proper course to pursue, for in many cases his responsibility both to the individual and to the community is great. He does not need to

*Read before the Rhode Island Medical Society, September 1, 1921.

know that our present classification, comprising some 60 odd forms of mental disease, is a compromise not wholly satisfactory to any one, or that we find many cases that do not seem to conform to any of these types. All he needs to determine is whether or not the case under consideration, in his judgment, needs hospital care. We do not expect, nor do we consider it any reflection upon the physician's intelligence, if he does not make a diagnosis for us. Inasmuch as psychiatrists often disagree among themselves it is not to be expected that a general practitioner's diagnosis would in all cases pass unchallenged in our clinics. A description of the patient's conduct and the reasons for his committal would often be more helpful than opinions. I remember well a certificate offered by two physicians in Vermont over 20 years ago, in which they glibly stated that "This patient has under our observation passed through the several states of mania, melancholia, paresis to dementia, and no longer possesses his rational, ideational or volitional powers."

In many states a copy of the physician's certificate accompanies the mittimus to the hospital and while one like the above might be of little service there are many borderline cases, and cases of mutism or concealed delusions where it would be of great assistance to the hospital if we but knew the facts upon which the committal was based, and it seems that this requirement might well be incorporated in the Rhode Island statutes.

In examining a case for committal there are certain symptoms for which the average physician looks, viz.: maniacal excitement, incoherence, dementia, melancholia or delusions. With one or two of these symptoms he usually considers himself justified in committing the case. If, on the other hand, the patient is a glib and fluent talker, is coherent, reveals shrewdness and wit, is clever in concealing his delusions, and is not too extravagant in his claims, they will often refuse to commit the man. regarding him perhaps as eccentric, but not insane, until he commits some overt act that stamps him as a menace to the community, when he is promptly committed after the harm is done.

While we should zealously guard the rights of the individual, we must not be insensitive to the rights of the family or the community for their claims are, after all, paramount. It has been decreed that men must adapt themselves to certain requirements of society or suffer the penalty. Consequently when we find a man constantly invading these rights, or evading these requirements, it is incumbent upon us to see that his activities be restrained until his mental status can be established and his capacity for doing harm can be determined.

One often hears the statement that there are more insane at large than we have in our institutions, and this is quite possibly true, but evidently the vast majority of these are meeting the chief test that we can apply and that is the ability to care for themselves and adjust themselves to their environment. Harmless eccentricities which do not impinge upon the rights of others may be ignored, even delusions are not inconsistent with the man's ability to accumulate wealth and be a good citizen, but when his reactions to these delusions or fancied grievances lead him to threaten retaliation upon his so-called enemies it is time that some action be taken.

In the crowded condition of our institutions it is necessary that we parole or discharge a large number of insane every year and before doing so we wish to satisfy ourselves upon the following points: Will he do harm to himself or others? Will he be a source of anxiety or annoyance in the community? and can he support himself or has he friends who will be responsible for his care and support?

We frequently release patients who have active delusions of persecution, but not until we are well satisfied regarding the probable reaction of such cases to their delusions. While the positive aggressive character, possessed of persecutory delusions, should be regarded as a dangerous type, we have the negative characters who will whine and cringe like a whipped dog who dares not even snap at his persecutor.

It will be seen that the question largely resolves itself into a discussion of conduct within certain well defined and generally recognized limits. If the man has shown a marked departure from his usual habits of life that causes anxiety to his family or neighbors the cause of this change should be rigorously investigated

and salient features be not lightly dismissed. Many a case can put up a good front before the doctor, who is simply intolerable in his home. If he is of a seclusive or sullen temperament, is jealous, suspicious, unduly oversensitive, quick to take offense at fancied injuries, and his resentment leads him to make threats against others, prompt action should be taken. It is wholly probable that he has delusions of a persecutory nature and quite likely hallucinations of hearing When the average man is so quick to resent an affront one need not be surprised that the insane patient attacks his victim without a moment's warning prompted by imaginary voices which we cannot hear and by delusionary mental processes which we cannot comprehend. If the wife of a chronic alcoholic complains that her husband has delusions about her, you should recall that these cases are prone to have delusions regarding the fidelity of their wives and if one delays till he obtains some convincing proof of the man's insanity, he may find it in a tragedy.

I would suggest that you let us pass judgment upon the mental defectives who show vicious or anti-social tendencies, those born bereft of moral sense, the epileptics who are subject to violent outbreaks, the periodic drinker—if these attacks mean the alternative of a jail sentence—and all cases of marked conduct disorder with anti-social tendencies, whether attended with delusions or not. Quite a large percentage of our cases have no delusions or hallucinations and possibly none of the symptoms for which you naturally look, yet for one reason or another their committal was well justified.

I can best illustrate a few points that I have made by citing certain cases within my personal experience which will demonstrate how successfully delusions may be concealed.

Many years ago a young man was committed to Taunton with a history of delusions of persecution. For some weeks he was mute, he then began answering questions rather grudgingly but always coherently and evaded all my efforts to draw him out upon the subject of his delusions, though I had frequently caught him in the attitude of a listener when the ward was quiet, and his expression was always one of suspicion and resentfulness. Not until ten months after his committal, though I saw him twice daily, did he break the reserve surrounding him and give clear proof of his delusions, and on this morning, which happened to be one in which I was in great haste to get away, he held me for two hours pouring forth delusions of a dangerous type hardly allowing me to interrupt him with a question.

Another man of 30 became violently insane in a theatre, rushed down the aisle crying murder and running hatless down the street, fell into the arms of a policeman. He thought the Devil was after him and in his excitement, revealed so many delusions of a persecutory nature that it was evidently easy to commit him. By the time he reached the hospital he had regained his composure and flatly denied all the statements made concerning him. During his whole stay at the hospital his conduct was exemplary. He was always cheerful, ready to help in the ward work, frequently challenged me to a hand at cards on my trips, talked freely and intelligently upon the current topics of the day, and apparently upon every subject except the incidents leading to his committal. His sister and friends, who called, declared he was as well as ever and insisted upon his discharge. I refused because I considered him a dangerous man. When asked what his delusions were and what proof I had of them I could but answer, "I do not know. He will not tell me but I have caught him listening to false voices and I know that he cannot free himself from the delusions he had when he came." Upon their third visit they became so extremely insulting in their estimate of my knowledge ot insanity that I took the matter to the Superintendent, who replied, "Tell them if they will take that man to Gloverville, N. Y., where his residence is, and assure us that he will never again become a charge upon the State of Massachusetts I will discharge him." At that time it was customary to discharge outright cases leaving the State, but to parole for 60 days all other cases, and these were automatically discharged if not returned within the 60-day limit. This case was discharged but the relatives broke faith with us and took him back to Brockton instead. The patient, believing that he was on parole, conducted himself with perfect propriety for 60 days and on the 61st shot a policeman and at

last reports was in the hospital for the criminal insane.

Many years ago I took an insane woman into my home who was said to have active delusions of persecution and false hearing. Three times a day we sat with her at meals for a period of seven months, during which she gave no evidence of a delusion, neither was she considered insane among the neighbors with whom she freely mingled. With the exception of her facial expression and two or three occasions upon which I saw her turn suddenly and with an angry expression toward a member of my family who had spoken, I could have offered no convincing proof of her insanity until one day I found that she had appealed to the sheriff for the right to carry a revolver, and had sought shelter with neighbors saying that I was going to kill her and that she had seen me getting the knives ready with which to do it. When I went after her she tried to laugh this off, but I decided the time had arrived for a little more restraint than I was authorized at that time to give and I had her committed.

A classmate, who was lawyer of some prominence in Boston, married his boyhood sweetheart who had graduated from Smith College. Some years later without any cause she developed delusions of jealousy about her husband. These delusions involved no particular woman, but she became obsessed with the idea that she was going to lose her husband and her condition became such that she was committed to McLean Hospital. Here she showed marked improvement and her husband took her out against advice of the hospital physicians. I met her at a reunion about a year afterward when she appeared very happy and manifested no symptoms that attracted my attention. During a winter following the couple played cards two evenings a week with a physician who had had considerable experience with mental cases, and on but few occasions did she make any remarks that struck him as peculiar. When summer approached she went to their summer home and was accustomed daily to meet her husband at the afternoon train and drive him to their home. One day she met him with a two seated carriage and insisted upon occupying the rear seat. As soon as they had reached a secluded spot she sent three bullets into the back of his head killing him instantly, and later manifested no sorrow because she had forever removed him from the toils of designing women.

Now these were all dangerous types who were clever in concealing their delusions, even from one familiar with such cases, and if the history of your case resembles these and your intuition tells you that there is something wrong, though indefinable, take some action. Do not be satisfied with one or even two examinations and if you feel that you cannot commit the case, consult with a specialist or at least see that the case is kept under the closest observation that no harm be done to others.

There is another type of which I wish especially to speak, namely, of the dignified, well to do business man, highly respected in the community, whose keen judgment has won him a competency, yet who suddenly develops eccentricities of conduct not at all in keeping with his previous behavior, either in lapses in morals or in business judgment. Such cases will often make the most foolish and startling investments. They may be somewhat garrulous and familiar in their conversation, but because they seem to have no delusions the doctor will hesitate to commit, or the family flatly refuse to subject the husband and father to the humiliation of guardianship or committal till his property has been dissipated and the family is penniless.

For my illustration I will take the Superintendent of an Insane Hospital in a neighboring state. He had served in that capacity for nearly 20 years, was highly respected and an ideal husband and father. One of the first changes noticed was in his attitude toward his children. He declared that "he who spared the rod spoiled the child" and from being a very indulgent father, he began to whip his children unmercifully on the slightest provocation until their cries caused a protest among the neighbors. He became much excited over trivial matters in administration and lightly pigeon-holed important matters that demanded instant attention, until his inefficiency led to his retirement. Not long afterward I had occasion to take a short railroad trip with him and noting his mental condition I remarked a few days later to the executive officer of the State Board of Insanity,

whom I knew was his intimate friend and former associate upon the staff of the same hospital, that the doctor acted and talked like a paretic. He replied, "Why no, I don't think there is anything like that, but he has a nervous break-down and I hear Bright's Disease." The sequel I heard about three months later. He had saved little money but at this time a $15,000 life insurance policy matured and on one of his trips to the city he was induced to invest $7,000 in some fraudulent mining scheme. He became a little apprehensive upon his return home that night and agreed with his wife that he would go to the city the following day and get his money back, but upon his return the following evening it was found that the crooks had inveigled him into investing the other $8,000, none of which was recovered, and the family was left destitute while the doctor died a few weeks later in an asylum. This is illustrative of hundreds of cases, some of which have doubtless occurred within your own experience; but what made this seem particularly striking was the fact that the man himself was a psychiatrist and had upon the day I last saw him attended a funeral where he met a score of his fellows who conversed with him briefly without noticing the symptoms that could hardly have escaped any of them had their conversation been prolonged.

In citing the above cases it will be noted that all mention of specific forms of insanity has been studiously avoided and attention has been concentrated upon symptoms and conduct. Few persons reach the stage demanding committal without the fact becoming apparent to all about them that "something is wrong" with the individual, but so imperfect or erroneous is the layman's conception of insanity, that the case must manifest violence of advanced dementia before they think his committal justified. In the main the responsibility rests upon the general practitioner, to observe and properly evaluate the symptoms of those cases in his community who show marked changes in conduct or business judgment or harbor ideas of fancied grievances and persecutions, and in the light of tragedies that appear almost daily in our papers it is difficult to see how he can escape public censure if he is slow to act when a given case has been brought to his attention.

The history given by family or friends will often give the key to the case and the symptoms cited can usually be easily recognized by any general practitioner; for his knowledge of the rules governing human conduct and the usual reactions of the average individual to various situations, coupled with ordinary common sense, will enable him to satisfy himself as to whether or not a man's conduct is rational or if he needs hospital care. Having recognized the symptoms and failed to act, he can hardly escape feeling a guilty sense of responsibility for a murder which the subject so often commits, or for the tragedy, hardly less painful, when a large estate has been dissipated and elderly people left destitute, through the lack of moral courage on the part of the medical adviser who fears to offend his patient by taking the only rational step to protect the man from himself.

CASE REPORT

REPORT OF A CASE OF TORSION OF THE OMENTUM AND DOUBLE FEMORAL HERNIA.

By CHARLES O. COOKE, A. M., M. D.
Providence, R. I.

The patient, a women forty-eight years of age, was seen in consultation with Dr. J. B. Bryer on March 19, 1920, with the following history:

Five days ago, patient had a sudden attack of severe pain in the epigastrium. There was no nausea nor vomiting. The pain became more severe and localized in the right lower quadrant. Bowels were constipated. There was slight fever and acceleration of pulse. Four days after onset of symptons, a large mass was discovered in the right lower quadrant of the abdomen.

Past History. Has always been well except for a right femoral hernia of 20 years duration, which was operated sixteen years ago, but recurred within three weeks. Recently a small femoral hernia developed on the left side.

Physical examination of abdomen showed a tender mass in the right lower abdomen, the size of a large grape-fruit. Temperature was 100° and pulse 96. There was a large femoral hernia on the right and a small femoral hernia on the left. The leucocytes were 13,200. The probable

(Continued on page 140)

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R. I. Ophthalmological and Otological Society—2d Thursday—October, December, February, April and Annual at call of President Dr. A. A. Fisher, President; Dr. J. L. Dowling, Secretary-Treasurer.

EDITORIALS

THE STATE HOSPITAL FOR MENTAL DISEASES.

In public print and out of it we have heard much in regard to conditions and needs of the State Hospital at Howard.

Something of these needs was tersely but distinctly brought out by the Superintendent, Dr. Harrington, in his opening address at the meeting of the Rhode Island Medical Society, held at the State Hospital, September 1st, the text of which will be found in another column and to which the attention of the reader is recommended.

In the literary program, a number of papers were presented bearing upon many mental diseases and incapacities. It is regretted that owing to lack of space, we find it necessary to divide the publication of the series into two or more issues.

THE STATE HOSPITAL FOR MENTAL DISEASES.

At the September meeting of the Rhode Island Medical Society, held at the State Hospital for Mental Diseases, there was considerable spirited discussion of the conditions of that institution, the lack of funds appropriated by the Legislature for its upkeep, and the difficulties under which the Penal and Charitable Board labored.

Apparently the chief idea advanced as to the cause of the difficulties was that too much power is wielded by politicians, who are not inclined to follow suggestions made by those in touch with affairs at the Institution.

It has occurred to the writer that possibly there is another and more potent reason for this seeming disregard of advice on the part of the Legislature, and that is, that with a constantly increasing personnel of the Board, opinions on questions are apt to become more divergent and counsel to be so varied and confusing as to leave the members of Legislature confounded rather than illuminated. The Board has grown progressively from three members to five, to seven, and finally to nine. Its very size may be so unwieldly as to make its findings and suggestions resemble a congressional inquiry with its majority and minority reports.

If, as seems evident on the surface, the Board as now constituted is unable to impress the Financial Committee forcefully enough with its recommendations, would it not be wise to try the experiment of appointing a single well paid Commissioner of Penal and Charitable Institutions? Such an officer should be a man trained in the administration of such institutions, with an intimate knowledge of the requirements as to equipment and personnel and have keen business sense, and of such cultural attainments that his dictum would of necessity carry weight with the arbiters of the people's money. A commission of one man would, at least, have the advantage of unity of program.

MOTHERHOOD.

Probably never in all history has there been a time when woman has held the exalted position that she now occupies.

Back to the dawn of any form of organized thought that we may term civilization, and before, woman was the toy and often the slave of man; the only use of which was to serve his pleasure or comfort, and held as a necessary agent to perpetuate a race of *men*—even to-day in many of the unchristianized (so named) countries, the condition of woman has been but little improved and the attitude of subserviency is still extant.

This is susceptible to one interpretation "The right of the Mightiest" for it will hardly be denied that the male of most species is physically the more powerful and capable of subjecting his mate to his will.

Modern times, however, have admitted the sunlight of a sense of justice; thought and education have evolved a recognition of human rights and after centuries of artificial gloom and injustice the chrysalis has burst and woman has emerged, alert, intellectual, intuitive; developing a power and aptitude not altogether anticipated and her "place in the sun" has become assured; her genius and mental brilliancy have long since been accepted as in no sense secondary to mans. For good and for evil has she evoked her power, probably the most potent factor in the uplifting of mankind and by caprice or circumstance she has been more fatal to empires than have armies or disease.

Suddenly, however, a new era has opened and we find her entering fields of effort heretofore unexplored by woman; she is in the councils of municipalities and in the legislature; she drives a machine, she is an office manager and any of the professions is no longer a novelty to her. She is a machinist and a carpenter, she is meeting man upon his own (?) ground with the assumed desire of equal responsibility and equal rights.

To what does all this portend? Does she indeed desire to be the equal of man? Only that? Is she forsaking her transcendency for only that? And when attained, by reason of her physical frailties will the wheel of natural balance again revolve and Might again make her a victim to its power, forcing her through centuries, to fight her way through her cycle of fate?

There is a greater destiny; for though ambition or circumstance may urge toward a certain social or economic goal, no one may gainsay that the real, paramount destiny of woman must be motherhood, and while other things may be achieved, they are overshadowed by this immutable fact and deep in her intuitive mind is this knowledge firmly established.

Consider the little girl, natural and as yet unhampered by the veneer of conventionalities, coddling her toy doll, (and if she hasn't one, should speedily manufacture one from anything at hand) caressing and caring for it with profound solicitude and we have a picture of the maternal instinct which though in her later teens and early womanhood may be in a measure subdued, will never perish; for with all else or with nothing else, nothing may approach the majesty of motherhood and no woman, and for that matter, no man, can or may grasp the fullness of life who has never felt the trustful, clinging fingers of little ones and who is childless to the end; for when memories are our companions in the twilight of life, there can be no solitude like this. Though a mother may have been embittered by want and disappointed in her ambitions for herself or offspring, there will always live in her consciousness a knowledge that her measure of life has been more nearly complete and her real destiny has been in the great accomplishment of motherhood. In the realization of this with the modern freedom of thought and action is the true equality.

DEFECTIVES AS AUTOMOBILISTS.

It should be brought to the attention of the State Board of Public Roads that the licensing of persons defective either physically or mentally should receive more attention than it has in the past. It is thoroughly appreciated that many persons are being licensed to drive motor vehicles who are lacking in ordinary common sense and in the ability to use proper judgment in the case of an accident. This is, of course, to be expected among the many thousands who are licensed to drive in this State. It is not this class to whom we refer. We know of several instances where cripples have been licensed to drive automobiles. A few years ago a serious accident occurred in Providence in which the driver of the machine at fault was found to have a paralyzed leg, and this leg, equipped with a brace, was used to control the clutch. Another case has recently come to our attention in which the driver's legs were badly deformed. The bones are abnormally brittle and are likely to be broken at the slightest strain. However this man is licensed to drive motor vehicles. It is the duty of the State Board of Public Roads to protect the public against unfortunates of this class, and it should be brought to the attention of the Board that these persons are not physically fit to be entrusted with the grave responsibility of driving motor vehicles in our crowded streets.

SOCIETY MEETINGS

Quarterly Meeting of the Rhode Island Medical Society.

September 1, 1921.

The regular September Meeting of the Rhode Island Medical Society was held September 1, 1921, at the State Hospital for Mental Diseases, Howard, R. I. There were approximately 90 members present and the morning was spent in inspecting the buildings and equipment of the Hospital.

At 1 P. M. luncheon was served in the Chapel. Members of the Penal and Charitable Board, thro whose courtesy the meeting was held at the hospital, were present at the luncheon and the scientific meeting.

During the luncheon, an organ recital was given by Mr. Harry C. Kenyon and singing was furnished by a mixed choir of 50 patients of the State Hospital for Mental Diseases.

The meeting was formally called to order at 2 P. M. by the President, Dr. George S. Mathews.

The minutes of the annual meeting were read by the Secretary.

The chairman of the Penal and Charitable Board, Mr. Monahan, welcomed the society to the institution for its quarterly meeting.

The following papers were then presented:

I. The State Hospital for Mental Diseases, by Dr. Arthur H. Harrington, Superintendent, illustrated by lanterns slides, showing former and present conditions at the hospital.

II. Results of Systematic Treatment of

Syphilis in Mental Cases, by Dr. Howard I. Gosline.

III. General remarks on Endocrine Disorders and their relation to the individual, Dr. Frederick J. Farnell. (This paper was read by the Secretary, in Dr. Farnell's absence).

IV. Treatment of Thirty Selected Cases of Epilepsey with Luminal, Dr. William M. Hughes.

V. Whom Should We Commit? Dr. George B. Coon.

VI. The Value of Knowledge of Psychometric Methods to the Doctor. Dr. Banice Feinberg.

VII. Psychoses Following Head Injuries. Dr. Arthur H. Harrington.

A vote of thanks was extended to the Penal and Charitable Board, to Dr. Harrington and his Staff, for the courtesies extended the society.

Dr. J. W. Keefe eulogized Dr. Harrington and his work in improving the conditions at and building up to its present state, the State Hospital for Mental Diseases. He called attention to the hampering effect the lack of funds appropriated is having on the Hospital and urged every member of the Society to use his influence to arouse public interest in the need of proper financial support for the Institution.

Dr. G. T. Swarts presented the following resolution:

"Resolved, that in the opinion of the Rhode Island Medical Society, it is apparent that sufficient funds have not been appropriated by the State Legislature for the medical care of the inmates of the State Hospital for Mental Diseases, and it is hereby urged upon the Legislature to make every effort to provide sufficient funds for the above purpose." Seconded by Dr. C. H. Griffin. An amendment to the foregoing was offered by Dr. C. W. Skelton, providing for the appointment of committee of three to investigate conditions at the State Hospital for Mental Diseases in regard to the sense of the foregoing resolution and to report to the Society at its December meeting. This amendment was subsequently withdrawn by Dr. Skelton after it had been pointed out that any resolutions adopted at this meeting must be referred to the House of Delegates for final action. The original resolution was then passed.

Dr. Ira D. Hasbrouck deplored the lack of funds appropriated to the uses of various Institutions of the State and called attention to conditions at the School for Feeble Minded at Exeter. He advocated a Hospital for Epileptics.

Adjourned.

Secretary, J. W. LEECH, M. D.

WOONSOCKET DISTRICT MEDICAL SOCIETY.

At the last regular meeting of Woonsocket District Medical Society, held July 7th the following officers were elected for the coming year:

President—Dr. E. F. Hamlin of Slatersville.
First Vice President—Dr. A. A. Weeden.
Second Vice President—Dr. W. C. Rocheleau.
Secretary—Dr. A. H. Monty.
Treasurer—Dr. A. Constantiman.
Councillor—Dr. J. A. King.

Delegate to Rhode Island Medical Society—Dr. J. E. Tanguay.

Following the election of officers a very interesting and instructive address on "Infant Feeding" was given by Dr. Robert M. Curtiss of Boston, after which adjournment was taken to the nurses dining room and a very dainty luncheon was served by Miss Lucy Ayers, matron of the hospital, assisted by the nurses.

HOSPITALS

RHODE ISLAND HOSPITAL.

J. M. Peters, M. D., and D. L. Richardson, M. D. left Sunday, September 11, to attend the Hospital Superintendent's Convention at West Baden, Indiana.

Dr. William O. Rice returned from his annual vacation on September 12.

Dr. Niles Westcott leaves for his annual vacation on September 17.

Dr. Lucius C. Kingman is away for the month of September.

Dr. N. D. Harvey recently returned from a short vacation.

Dr. James F. Boyd is away for a two weeks vacation to recuperate from a recent attack of LaGrippe.

Mr. John E. Groff, apothecary, is now able to attend to part of his duties after a prolonged illness.

Dr. Charles E. Blackway finished a two year internship at the Rhode Island Hospital on October 1, and will practice in Fall River, Mass. Dr. Blackway was operated upon recently for acute appendicitis.

Dr. Maurice C. Miller finished a twenty-one months internship at the Rhode Island Hospital, October 1. He intends to take up surgical work at the Mayo Clinic.

The radium treatment under charge of Drs Pitts, Sawyer and Boyd have increased considerably. The necessity of purchasing more radium is under consideration.

The Appliance Shop established at the Out-Patient Department for the making of special splints, braces, foot plates, jackets and other orthopedic appliances is now in full operation.

The new gasoline propelled lawn mower presented to the hospital by Mr. Jesse H. Metcalf. President of the Board of Trustees, has been very successful as a labor and time saver during the summer.

The inside work on the Jane Frances Brown Building for private patients is progressing favorably after much delay caused by strikes in the building trades.

The Out-Patient Department has been completely repainted inside during the summer.

A tennis tournament among the internes was won by Dr. H. Russell Smith.

Dr. Halsey DeWolf and Dr. Geo. S. Mathews, visiting physicians, started their services September 1.

Drs. Charles E. Hawkes, Henry Hoye, John Ferguson and Frederick V. Hussey, visiting and assistant visiting surgeons, started their services September 1.

Dr. Hugo M. Kersten is serving as substitute interne during the vacation period.

Dr. Earl A. Bowen and Dr. William N. Hughes will start the regular two years service as internes on October 1.

RECENT APPOINTMENT TO THE OUT-PATIENT DEPARTMENT.

Dr. Earl R. White	Medical Department
Dr. Frank B. Berry	Medical Department
Dr. Henry B. Moor	Medical Department
Dr. Roy Blosser	Dermatological Department
Dr. Arthur E. Martin	Orthopedic Department
Dr. Joseph E. Raia,	Ophthalmological Department
Dr. Samuel Kennison	Children's Department

TRANSFERS.

Dr. Harold E. Miner has been transferred from the Medical Department to Gynecological Department.

A class of forty-seven probationers is expected for the September nurses class.

Respectfully,

NORMAN C. BAKER, M. D.
Secretary Staff Association.

(*Concluded from page 135*)

diagnosis seemed to be Appendiceal Abscess and operation was decided on.

March 20, 1920. Exploratory Laparotomy. Removal of strangulated omentum and appendectomy.

Four and one-half inch right rectus incision; the right lower quadrant of the abdomen was filled with haemorrhagie omentum, the tip of which was adherent to the right femoral canal. The omentum was hard and porky and strangulated by torsion of the pedicle. The tip of the omentum was freed from the femoral canal and the pedicle was ligated and cut away close to the transverse colon. This removed approximately one-half the omentum, the other half being normal. The appendix was normal and was removed in the usual manner. Pelvic organs, gall bladder and other organs were apparently normal. The incision was closed in layers without drainage. Convalescence was uneventful and the incision healed per primeau.

On March 30, 1920, a second operation was performed for cure of double femoral hernia. The sac on the right side was very large and in intimate relation to the femoral vein. The sac on the left side was much smaller.

Convalescence was uneventful and both wounds healed per primeau.

The patient has remained entirely well to date.

COMMENT. Torsion of the omentum is a rare condition, but must be added to the large number of conditions which cause the acute abdomen.